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CHALENG 2005 Survey: El Paso VA HCS, TX - 756

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 105

2. Estimated Number of Veterans who are Chronically Homeless: 27

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 105 (estimated number of homeless veterans in service area) **x chronically homeless rate (26 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	353	0
Transitional Housing Beds	217	40
Permanent Housing Beds	10	90

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Develop Shelter Plus Care program, a new initiative partnership with the City of El Paso Housing Authority. Inquire about possible availability of Section 8 vouchers in Anthony, Texas.
Transitional living facility or halfway house	Continue to encourage and promote submission of VA grants. El Paso currently has only one GPD program with a 20-bed capacity.
Help finding a job or getting employment	Invite representatives from local employment agencies (Goodwill, Habitat for Humanity, Upper Rio Grande Work Force, NCED, the TACE program) to a monthly CHALENG subcommittee meeting to establish a strong working relationship.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **94 Non-VA staff Participants: 83.5%**
Homeless/Formerly Homeless: **29.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.64	2.0%	3.47
Food	3.98	10.0%	3.80
Clothing	3.68	10.0%	3.61
Emergency (immediate) shelter	3.97	11.0%	3.33
Halfway house or transitional living facility	3.60	15.0%	3.07
Long-term, permanent housing	2.79	41.0%	2.49
Detoxification from substances	3.27	10.0%	3.41
Treatment for substance abuse	3.40	13.0%	3.55
Services for emotional or psychiatric problems	3.4	12.0%	3.46
Treatment for dual diagnosis	3.3	8.0%	3.30
Family counseling	3.05	3.0%	2.99
Medical services	3.85	13.0%	3.78
Women's health care	3.37	3.0%	3.23
Help with medication	3.63	2.0%	3.46
Drop-in center or day program	3.04	6.0%	2.98
AIDS/HIV testing/counseling	3.58	.0%	3.51
TB testing	3.84	.0%	3.71
TB treatment	3.70	.0%	3.57
Hepatitis C testing	3.68	1.0%	3.63
Dental care	3.00	24.0%	2.59
Eye care	2.97	15.0%	2.88
Glasses	2.94	8.0%	2.88
VA disability/pension	3.45	11.0%	3.40
Welfare payments	3.27	.0%	3.03
SSI/SSD process	3.34	3.0%	3.10
Guardianship (financial)	3.10	2.0%	2.85
Help managing money	3.13	2.0%	2.87
Job training	2.94	13.0%	3.02
Help with finding a job or getting employment	2.94	16.0%	3.14
Help getting needed documents or identification	3.46	8.0%	3.28
Help with transportation	3.41	9.0%	3.02
Education	3.44	8.0%	3.00
Child care	2.92	3.0%	2.45
Legal assistance	3.21	6.0%	2.71
Discharge upgrade	3.05	2.0%	3.00
Spiritual	3.01	2.0%	3.36
Re-entry services for incarcerated veterans	2.79	7.0%	2.72
Elder Healthcare	2.94	2.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.70
Co-location of Services - Services from the VA and your agency provided in one location.	2.21
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.21
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.48
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.13
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.17
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.13
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.60
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.38
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.88
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.15
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.47

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.55

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CHALENG 2005 Survey: VA New Mexico HCS - 501

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 902

2. Estimated Number of Veterans who are Chronically Homeless: 307

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 902 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	548	250
Transitional Housing Beds	385	650
Permanent Housing Beds	532	450

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Will continue to support two agencies that have experienced delays in their VA GPD programs. Continue outreach efforts to community agencies in Albuquerque and Gallup developing transitional living programs.
Long-term, permanent housing	Our VA is part of the Albuquerque Mental Health Housing Coalition (AMHHC). AMHHC is expanding to provide services throughout the state and changing its name to Supportive Housing Coalition of New Mexico.
Immediate shelter	Will continue collaboration with the Albuquerque Opportunity Center in their efforts to operate at maximum capacity.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **19 Non-VA staff Participants: 77.8%**
Homeless/Formerly Homeless: **15.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.17	.0%	3.47
Food	3.50	13.0%	3.80
Clothing	3.47	.0%	3.61
Emergency (immediate) shelter	2.83	27.0%	3.33
Halfway house or transitional living facility	2.78	27.0%	3.07
Long-term, permanent housing	2.33	20.0%	2.49
Detoxification from substances	2.61	13.0%	3.41
Treatment for substance abuse	2.88	7.0%	3.55
Services for emotional or psychiatric problems	2.8	13.0%	3.46
Treatment for dual diagnosis	2.9	13.0%	3.30
Family counseling	2.89	.0%	2.99
Medical services	3.39	20.0%	3.78
Women's health care	2.78	13.0%	3.23
Help with medication	3.22	.0%	3.46
Drop-in center or day program	3.22	.0%	2.98
AIDS/HIV testing/counseling	3.25	7.0%	3.51
TB testing	3.41	.0%	3.71
TB treatment	3.44	.0%	3.57
Hepatitis C testing	3.33	.0%	3.63
Dental care	2.89	13.0%	2.59
Eye care	2.88	13.0%	2.88
Glasses	2.82	.0%	2.88
VA disability/pension	3.11	20.0%	3.40
Welfare payments	2.82	.0%	3.03
SSI/SSD process	3.00	7.0%	3.10
Guardianship (financial)	2.94	.0%	2.85
Help managing money	2.78	7.0%	2.87
Job training	2.94	7.0%	3.02
Help with finding a job or getting employment	3.12	13.0%	3.14
Help getting needed documents or identification	3.22	7.0%	3.28
Help with transportation	2.72	7.0%	3.02
Education	2.94	.0%	3.00
Child care	2.33	7.0%	2.45
Legal assistance	2.50	7.0%	2.71
Discharge upgrade	2.72	.0%	3.00
Spiritual	2.89	.0%	3.36
Re-entry services for incarcerated veterans	2.65	20.0%	2.72
Elder Healthcare	2.76	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.79
Co-location of Services - Services from the VA and your agency provided in one location.	2.31
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.14
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.64
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.64
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.86
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.93
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.57
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.57
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.07

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.43
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71

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CHALENG 2005 Survey: VA Northern Arizona HCS - 649

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 850

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 850 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	79	0
Transitional Housing Beds	167	20
Permanent Housing Beds	40	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Outside social/community resources are limited due to Prescott and surrounding communities being small or remote.
Transitional living facility or halfway house	Outside social/community resources are limited due to Prescott and surrounding communities being small or remote.
Long-term, permanent housing	Outside social/community resources are limited due to Prescott and surrounding communities being small or remote.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **7** **Non-VA staff Participants: 83.3%**
Homeless/Formerly Homeless: **57.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.57	.0%	3.47
Food	3.86	.0%	3.80
Clothing	3.86	.0%	3.61
Emergency (immediate) shelter	3.14	29.0%	3.33
Halfway house or transitional living facility	3.00	57.0%	3.07
Long-term, permanent housing	2.50	14.0%	2.49
Detoxification from substances	3.43	29.0%	3.41
Treatment for substance abuse	4.00	14.0%	3.55
Services for emotional or psychiatric problems	3.9	.0%	3.46
Treatment for dual diagnosis	3.3	.0%	3.30
Family counseling	3.43	.0%	2.99
Medical services	4.14	.0%	3.78
Women's health care	2.86	14.0%	3.23
Help with medication	3.86	.0%	3.46
Drop-in center or day program	3.71	14.0%	2.98
AIDS/HIV testing/counseling	3.14	.0%	3.51
TB testing	4.29	.0%	3.71
TB treatment	4.29	.0%	3.57
Hepatitis C testing	4.43	.0%	3.63
Dental care	2.71	57.0%	2.59
Eye care	3.00	29.0%	2.88
Glasses	3.43	14.0%	2.88
VA disability/pension	4.00	.0%	3.40
Welfare payments	3.43	.0%	3.03
SSI/SSD process	3.71	.0%	3.10
Guardianship (financial)	3.43	.0%	2.85
Help managing money	3.71	.0%	2.87
Job training	3.43	.0%	3.02
Help with finding a job or getting employment	4.43	.0%	3.14
Help getting needed documents or identification	4.14	.0%	3.28
Help with transportation	3.29	14.0%	3.02
Education	4.14	.0%	3.00
Child care	2.86	.0%	2.45
Legal assistance	3.71	.0%	2.71
Discharge upgrade	3.57	.0%	3.00
Spiritual	4.67	.0%	3.36
Re-entry services for incarcerated veterans	3.29	.0%	2.72
Elder Healthcare	3.71	14.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.50
Co-location of Services - Services from the VA and your agency provided in one location.	3.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.50
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.20
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.20

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CHALENG 2005 Survey: VA Southern Arizona HCS - 678

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 250

2. Estimated Number of Veterans who are Chronically Homeless: 68

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 250 (estimated number of homeless veterans in service area) **x chronically homeless rate (27 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	100
Transitional Housing Beds	98	200
Permanent Housing Beds	345	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Partner with community agencies, apply for VA/HUD grants to establish or expand transitional/permanent living options.
Long-term, permanent housing	Work towards expanding our Shelter Plus Care bed allocation. Explore new long-term housing options through our participation in local monthly planning meetings and grant applications.
Dental care	Continue to work towards expanding existing VA dental services while exploring new partnership opportunities in the community.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **36** **Non-VA staff Participants: 58.8%**
Homeless/Formerly Homeless: **5.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.71	.0%	3.47
Food	3.97	19.0%	3.80
Clothing	3.83	6.0%	3.61
Emergency (immediate) shelter	3.60	23.0%	3.33
Halfway house or transitional living facility	3.39	26.0%	3.07
Long-term, permanent housing	2.60	42.0%	2.49
Detoxification from substances	3.69	.0%	3.41
Treatment for substance abuse	3.74	13.0%	3.55
Services for emotional or psychiatric problems	3.6	10.0%	3.46
Treatment for dual diagnosis	3.6	10.0%	3.30
Family counseling	3.09	.0%	2.99
Medical services	3.81	3.0%	3.78
Women's health care	3.46	.0%	3.23
Help with medication	3.50	3.0%	3.46
Drop-in center or day program	3.03	3.0%	2.98
AIDS/HIV testing/counseling	3.53	.0%	3.51
TB testing	3.97	.0%	3.71
TB treatment	3.81	.0%	3.57
Hepatitis C testing	3.72	.0%	3.63
Dental care	2.25	42.0%	2.59
Eye care	2.36	10.0%	2.88
Glasses	2.44	6.0%	2.88
VA disability/pension	3.33	6.0%	3.40
Welfare payments	3.03	.0%	3.03
SSI/SSD process	3.00	19.0%	3.10
Guardianship (financial)	2.83	.0%	2.85
Help managing money	2.83	.0%	2.87
Job training	2.89	10.0%	3.02
Help with finding a job or getting employment	2.89	16.0%	3.14
Help getting needed documents or identification	3.08	3.0%	3.28
Help with transportation	2.89	3.0%	3.02
Education	2.56	3.0%	3.00
Child care	2.39	3.0%	2.45
Legal assistance	2.58	3.0%	2.71
Discharge upgrade	2.83	.0%	3.00
Spiritual	3.26	6.0%	3.36
Re-entry services for incarcerated veterans	2.80	3.0%	2.72
Elder Healthcare	3.00	6.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.70
Co-location of Services - Services from the VA and your agency provided in one location.	2.10
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.85
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.63
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.95
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.05
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.85
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.60
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.10
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.90
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.80
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.75

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.50
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.45

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Amarillo, TX - 504

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 100

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 100 (estimated number of homeless veterans in service area) **x chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	509	0
Transitional Housing Beds	105	158
Permanent Housing Beds	37	296

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Coalition members will submit requests for funding for permanent housing.
Transitional living facility or halfway house	Coalition members will submit requests for funding for transitional housing.
Help finding a job or getting employment	VA in conjunction with local agencies will submit requests for funding to establish programs to assist in job development, training, etc.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **25** **Non-VA staff Participants: 96.0%**
Homeless/Formerly Homeless: **4.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.28	4.0%	3.47
Food	3.60	13.0%	3.80
Clothing	3.68	8.0%	3.61
Emergency (immediate) shelter	2.92	33.0%	3.33
Halfway house or transitional living facility	2.48	38.0%	3.07
Long-term, permanent housing	2.56	42.0%	2.49
Detoxification from substances	2.92	17.0%	3.41
Treatment for substance abuse	2.84	21.0%	3.55
Services for emotional or psychiatric problems	2.9	8.0%	3.46
Treatment for dual diagnosis	2.8	4.0%	3.30
Family counseling	2.96	4.0%	2.99
Medical services	3.32	13.0%	3.78
Women's health care	3.08	.0%	3.23
Help with medication	3.16	13.0%	3.46
Drop-in center or day program	3.04	4.0%	2.98
AIDS/HIV testing/counseling	3.36	.0%	3.51
TB testing	3.36	.0%	3.71
TB treatment	3.21	.0%	3.57
Hepatitis C testing	3.44	.0%	3.63
Dental care	2.56	21.0%	2.59
Eye care	2.88	8.0%	2.88
Glasses	2.96	4.0%	2.88
VA disability/pension	3.68	.0%	3.40
Welfare payments	3.16	.0%	3.03
SSI/SSD process	3.00	4.0%	3.10
Guardianship (financial)	2.79	.0%	2.85
Help managing money	2.80	13.0%	2.87
Job training	2.96	4.0%	3.02
Help with finding a job or getting employment	3.04	12.0%	3.14
Help getting needed documents or identification	3.08	.0%	3.28
Help with transportation	2.40	4.0%	3.02
Education	3.00	4.0%	3.00
Child care	2.56	.0%	2.45
Legal assistance	2.96	.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.12	.0%	3.36
Re-entry services for incarcerated veterans	2.76	4.0%	2.72
Elder Healthcare	3.04	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.29
Co-location of Services - Services from the VA and your agency provided in one location.	1.54
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.74
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.67
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.38
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.88
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.79
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.46
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.43
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.55

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.70

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CHALENG 2005 Survey: VA West Texas HCS - 519

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1500

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1500 (estimated number of homeless veterans in service area) **x chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	12	20
Transitional Housing Beds	0	75
Permanent Housing Beds	0	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Assist nonprofit organizations with statistics on homeless veterans in order to help them to apply for grants and community funding for transitional housing.
Job training	Deal closely with local colleges, technical schools. Help veterans access college benefits. Use Texas Rehab as a resource.
Help finding a job or getting employment	Deal more closely with Texas Workforce Center and attend as many job fairs as possible.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **7** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.14	17.0%	3.47
Food	3.57	.0%	3.80
Clothing	3.43	.0%	3.61
Emergency (immediate) shelter	2.83	17.0%	3.33
Halfway house or transitional living facility	2.14	33.0%	3.07
Long-term, permanent housing	2.00	17.0%	2.49
Detoxification from substances	3.33	17.0%	3.41
Treatment for substance abuse	3.33	17.0%	3.55
Services for emotional or psychiatric problems	3.5	17.0%	3.46
Treatment for dual diagnosis	3.5	.0%	3.30
Family counseling	3.33	.0%	2.99
Medical services	3.67	.0%	3.78
Women's health care	3.20	.0%	3.23
Help with medication	3.17	.0%	3.46
Drop-in center or day program	2.71	.0%	2.98
AIDS/HIV testing/counseling	2.43	33.0%	3.51
TB testing	3.33	.0%	3.71
TB treatment	3.17	.0%	3.57
Hepatitis C testing	3.17	.0%	3.63
Dental care	2.67	17.0%	2.59
Eye care	2.67	.0%	2.88
Glasses	2.67	.0%	2.88
VA disability/pension	3.00	.0%	3.40
Welfare payments	3.17	.0%	3.03
SSI/SSD process	3.17	17.0%	3.10
Guardianship (financial)	2.83	17.0%	2.85
Help managing money	2.71	.0%	2.87
Job training	3.29	17.0%	3.02
Help with finding a job or getting employment	3.43	33.0%	3.14
Help getting needed documents or identification	2.86	.0%	3.28
Help with transportation	3.14	.0%	3.02
Education	3.17	17.0%	3.00
Child care	3.00	.0%	2.45
Legal assistance	3.14	.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.43	.0%	3.36
Re-entry services for incarcerated veterans	2.50	.0%	2.72
Elder Healthcare	2.83	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.71
Co-location of Services - Services from the VA and your agency provided in one location.	1.43
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.57
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.29
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.14
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.33
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.29
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.29

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.43
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.43

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Phoenix, AZ - 644

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2537

2. Estimated Number of Veterans who are Chronically Homeless: 863

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2537 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	400	150
Transitional Housing Beds	89	137
Permanent Housing Beds	12	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 9

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Explore establishing additional transitional housing for veterans through formal, informal or contractual agreements within the community.
Long-term, permanent housing	Will continue to partner with the Arizona Coalition to End Homelessness, Governors Task Force to End Homelessness, and other community groups.
Dental care	Partner with Central Arizona Shelter Services Dental Clinic in establishing a formal or informal agreement in providing dental services for our homeless veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **45** **Non-VA staff Participants: 59.1%**
Homeless/Formerly Homeless: **22.2%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.47	.0%	3.47
Food	3.84	2.0%	3.80
Clothing	3.55	.0%	3.61
Emergency (immediate) shelter	3.31	20.0%	3.33
Halfway house or transitional living facility	2.98	23.0%	3.07
Long-term, permanent housing	2.20	35.0%	2.49
Detoxification from substances	3.09	7.0%	3.41
Treatment for substance abuse	3.31	16.0%	3.55
Services for emotional or psychiatric problems	3.3	7.0%	3.46
Treatment for dual diagnosis	3.0	5.0%	3.30
Family counseling	2.73	5.0%	2.99
Medical services	3.91	12.0%	3.78
Women's health care	3.10	7.0%	3.23
Help with medication	3.53	5.0%	3.46
Drop-in center or day program	2.67	14.0%	2.98
AIDS/HIV testing/counseling	3.30	2.0%	3.51
TB testing	3.64	.0%	3.71
TB treatment	3.43	.0%	3.57
Hepatitis C testing	3.66	.0%	3.63
Dental care	1.96	34.0%	2.59
Eye care	2.14	12.0%	2.88
Glasses	2.25	7.0%	2.88
VA disability/pension	3.27	16.0%	3.40
Welfare payments	2.44	.0%	3.03
SSI/SSD process	2.88	12.0%	3.10
Guardianship (financial)	2.55	.0%	2.85
Help managing money	2.40	2.0%	2.87
Job training	2.84	7.0%	3.02
Help with finding a job or getting employment	3.47	14.0%	3.14
Help getting needed documents or identification	3.25	2.0%	3.28
Help with transportation	3.27	2.0%	3.02
Education	2.89	2.0%	3.00
Child care	2.05	5.0%	2.45
Legal assistance	2.31	5.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	2.89	.0%	3.36
Re-entry services for incarcerated veterans	2.28	25.0%	2.72
Elder Healthcare	2.83	2.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.63
Co-location of Services - Services from the VA and your agency provided in one location.	2.08
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.83
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.30
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.50
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.83
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.79
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.25
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.83
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.65
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.96

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.61
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.42